U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 18 November 2005

Case No. 2003-BLA-6539

In the Matter of:
DONALD HOLBROOK,
Claimant,

v.

APOGEE COAL CO.,
/ARCH OF KENTUCKY,
Employer,
and
SELF-INSURED THROUGH ARCH
COAL, INC., c/o UNDERWRITERS
SAFETY AND CLAIMS,
Carrier,

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party in Interest.

APPEARANCES:
Mark L. Ford, Esq.
On behalf of Claimant

Denise M. Davidson, Esq.
On behalf of Employer/Carrier

BEFORE: Thomas F. Phalen, Jr.
Administrative Law Judge

DECISION AND ORDER – DENIAL OF BENEFITS

This is a decision and order arising out of a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977, 30 U.S.C. §§ 901-962, ("the Act") and the regulations thereunder, located in Title 20 of

the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.[1]

On August 8, 2003, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs, for a hearing. (DX 33).[2] A formal hearing on this matter was conducted on January 4, 2004, in Harlan, Kentucky, by the undersigned Administrative Law Judge. All parties were afforded the opportunity to call and to examine and cross examine witnesses, and to present evidence, as provided in the Act and the above referenced regulations.

ISSUES[3]

The issues in this case are:

1. Whether the Claimant had pneumoconiosis as defined by the Act and the regulations;

2. Whether the Claimant's pneumoconiosis arose out of coal mine employment;

3. Whether the Claimant is totally disabled;

4. Whether Claimant's disability was due to pneumoconiosis; and

5. Whether the Claimant has established a material change in conditions per §725.309(c), (d).[4]

(DX 33).

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

[1] The Department of Labor amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended. These regulations became effective on January 19, 2001, and are found at 65 Fed. Reg. 80, 045-80,107 (2000)(to be codified at 20 C.F.R. Parts 718, 722, 725 and 726). On August 9, 2001, the United States District Court for the District of Columbia issued a Memorandum and Order upholding the validity of the new regulations. All citations to the regulations, unless otherwise noted, refer to the amended regulations.

[2] In this Decision, "DX" refers to the Director's Exhibits, "EX" refers to the Employer's Exhibits, "CX" refers to the Claimant's Exhibits, and "Tr." refers to the official transcript of this proceeding.

[3] At the hearing the Employer withdrew as uncontested the issue of responsible operator. (Tr. 15). Also, timeliness was marked as withdrawn on a copy of DX 33, and initialed by the parties. I have marked this exhibit ALJ 2, and it represents a change to DX 33. Finally, Employer listed other issues that will not be decided by the undersigned, however, they are preserved for appeal. (DX 33, Item 18).

[4] While not marked as a contested issue, a review of the record reveals that this is a subsequent claim and will be adjudicated accordingly.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background

Donald Holbrook ("Claimant") was born on March 7, 1939; he was 65 years-old at the time of the hearing. (DX 3, 21; Tr. 13). He completed the third grade. (DX 3, 21). On June 9, 1961, he married Janice Bledsoe, and they remain married and live together. (DX 3). Mr. Holbrook does not claim any additional dependents. (DX 3, 21). Therefore, I find that Claimant has one dependent for purposes of augmentation.

On his application for benefits, Claimant alleged that he engaged in underground coal mine employment for 18 ½ years. (DX 3). At his deposition, Claimant stated that all of his coal mine employment was underground. (DX 21:5). He last worked the belt line, where he shoveled coal and operated a shuttle car. (DX 5, 21:5; Tr. 14). On his employment summary form, Claimant stated that this position required Claimant to stand for 2 to 10 hours per day, and lift and carry 50 to 100 pounds. (DX 5). However, at the hearing Claimant stated that his job was "pretty easy" and that it involved mostly sitting all day in a shuttle car and required little heavy lifting. (Tr. 14-15). Claimant last worked in and around coal mines in 1995. (DX 3, 21; Tr. 13). Claimant also noted that he received payments from 1992 through 1996 for a State Workers' Compensation claim. (DX 3, 21:9; Tr. 18).

Procedural History

Claimant filed his initial claim for benefits under the Act on November 3, 1997. (DX 1). The District Director, Officer of Workers' Compensation issued a letter on March 3, 1998 notifying Claimant that he did not qualify for benefits based on the evidence of record. After consideration of additional evidence, the Director issued a letter on June 10, 1998 reiterating the previous finding. Claimant did not appeal the Director's denial of benefits.

On December 14, 2001, Claimant filed the instant claim for benefits under the Act. (DX 3). The Director issued a proposed decision and order – denial of benefits on May 14, 2003. (DX 24). Following Claimant's request for a revision, (DX 25), Director issued a revised proposed decision and order – denial of benefits on May 21, 2003. (DX 26). Claimant again requested a revision, (DX 28), and Director issued a second revised proposed decision and order – denial of benefits on June 4, 2003. (DX 29). Claimant timely requested a formal hearing before the Office of Administrative Law Judges. (DX 30). The matter was transferred to this office on August 20, 2003. (DX 33).

Length of Coal Mine Employment

On his application for benefits, Claimant stated that he engaged in coal mine employment for 18 ½ years. (DX 3). At the hearing, however, he claimed to have worked 20 years in the mines. (Tr. 13). The Director, in a revised proposed decision and order dated June 4, 2003, determined that Claimant has at least 17 years of coal mine employment. (DX 29). The parties have stipulated that the Claimant worked at least 18 years in or around one or more coal mines.

(DX 33). I find that the record supports this stipulation, (DX 4-6), and therefore, I hold that the Claimant worked at least 18 years in or around one or more coal mines.

Claimant's last employment was in the Commonwealth of Kentucky, therefore, the law of the Sixth Circuit is controlling. [5]

Responsible Operator

Liability under the Act is assessed against the most recent operator which meets the requirements of §§ 725.494 and 725.495. The District Director identified Apogee Coal Co. as the putative responsible operator due to the fact that it was the last company to employ Claimant for a full year. (DX 16). Employer does not contest its designation as responsible operator. (Tr. 15). Therefore, I find that Apogee Coal Co. is properly designated as the responsible operator in this case.

MEDICAL EVIDENCE

Section 718.101(b) requires any clinical test or examination to be in substantial compliance with the applicable standard in order to constitute evidence of the fact for which it is proffered. *See* §§ 718.102 - 718.107. The claimant and responsible operator are entitled to submit, in support of their affirmative cases, no more than two chest x-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two blood gas studies, no more than one report of each biopsy, and no more than two medical reports. §§ 725.414(a)(2)(i) and (3)(i). Any chest x-ray interpretations, pulmonary function studies, blood gas studies, biopsy report, and physician's opinions that appear in a medical report must each be admissible under § 725.414(a)(2)(i) and (3)(i) or § 725.414(a)(4). §§ 725.414(a)(2)(i) and (3)(i). Each party shall also be entitled to submit, in rebuttal of the case presented by the opposing party, no more than one physician's interpretation of each chest x-ray, pulmonary function test, arterial blood gas study, or biopsy submitted, as appropriate, under paragraphs (a)(2)(i), (a)(3)(i), or (a)(3)(iii). §§ 725.414(a)(2)(ii), (a)(3)(ii), and (a)(3)(iii). Notwithstanding the limitations of §§ 725.414(a)(2) or (a)(3), any record of a miner's hospitalization for a respiratory or pulmonary or related disease, or medical treatment for a respiratory or pulmonary or related disease, may be received into evidence. § 725.414(a)(4). The results of the complete pulmonary examination shall not be counted as evidence submitted by the miner under § 725.414. § 725.406(b).

Claimant selected Dr. Glen Baker to provide his Department of Labor sponsored complete pulmonary examination. (DX 7). Dr. Baker conducted the examination on February 5, 2002. I admit Dr. Baker's report under § 725.406(b). I also admit Dr. Sargent's quality-only interpretation of the chest x-ray and Dr. Burki's validation of the PFT under § 725.406(c).

Claimant completed a Black Lung Benefits Act Evidence Summary Form. (CX 1). Aside from the DOL sponsored examination, Claimant's only designations were Dr. Lockey's April 4, 2002 PFT and ABG studies. Claimant's evidence complies with the requisite quality

[5] Appellate jurisdiction with a federal circuit court of appeals lies in the circuit where the miner last engaged in coal mine employment, regardless of the location of the responsible operator. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200 (1989)(en banc).

standards of §718.102-107 and the limitations of §725.414(a)(3). Therefore, I admit Claimant's evidence.

Employer most recent Black Lung Benefits Act Evidence Summary Form was submitted on March 16, 2005. (EX 4). Employer designated Dr. Lockey's and Dr. Wiot's April 4, 2002 x-ray interpretations as initial evidence, and Dr. Wiot's reading of the February 5, 2002 film as rebuttal evidence. Next, Employer designated Dr. Lockey's April 4, 2002 PFT and ABG studies. Turning to the medical reports, Employer lists Dr. Jarboe's December 2003 report, his February 2005 supplement, and his February 2005 supporting deposition; and Dr. Lockey's April 4, 2002 report, and his December 2003 supporting deposition.[6] As Dr. Jarboe's 2003 and 2005 reports are both medical evidence reviews, I find that these separate documents constitute one medical report under the limitations of §725.414. As a result, I find that Employer's designations comply with the requisite quality standards of §718.102-107 and the limitations of §725.414(a)(3). Therefore, I admit Employer's evidence as designated on the March 2005 summary form.

At the hearing the parties jointly agreed to inclusion of recent treatment records. These records are included as exhibit 2 of EX 6, and are admitted as hospitalization records and treatment notes under §725.3414(a)(4).

X-RAYS

Exhibit	**Date of X-ray**	**Date of Reading**	**Physician / Credentials**	**Interpretation**
DX 12	2/5/02	2/05/02	Baker[7]	1/0 pp
DX 13	2/5/02	4/10/02	Sargent, BCR[8], B-reader[9]	Quality only
EX 2	2/5/02	8/05/03	Wiot, BCR, B-reader	Negative
DX 14; EX 1	4/4/02	4/04/02	Lockey, B-reader	Negative
DX 14	4/4/02	4/05/02	Wiot, BCR, B-reader	Negative

[6] These reports were actually listed under the ABG rehabilitative and rebuttal evidence heading, but considering their content, it is apparent that they were intended as medical reports.

[7] At the time of the x-ray reading, Dr. Baker did not hold B-reader x-ray interpretation credentials. But the June 7, 2004 "B-reader" list states that he was a B-reader from February 1, 1993 to January 31, 2001, and again from June 1, 2002 to present. Also, he is listed as an A-reader from February 1, 2001 to May 31, 2002.

[8] A physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. *See* 20 C.F.R. § 727.206(b)(2)(III). The qualifications of physicians are a matter of public record at the National Institute of Occupational Safety and Health reviewing facility at Morgantown, West Virginia.

[9] A "B" reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successful completion of an examination conducted by or on behalf of the Department of Health and Human Services. This is a matter of public record at HHS National Institute for Occupational Safety and Health reviewing facility at Morgantown, West Virginia. (42 C.F.R. § 37.5l) Consequently, greater weight is given to a diagnosis by a "B" Reader. *See Blackburn v. Director, OWCP*, 2 B.L.R. 1-153 (1979).

PULMONARY FUNCTION TESTS

Exhibit/ Date	**Co-op./ Undst./ Tracings**	**Age/ Height**	**FEV_1**	**FVC**	**MVV**	**FEV_1/ FVC**	**Qualifying Results**
DX 10 2/5/02	Fair/ Good/ Yes	62 65"	**1.59**	3.35	---	**47.5**	Yes[10]
DX 14 4/4/02	Maximal effort/ Yes	63 65"	**1.41** **1.36***	2.85 2.79*	---	**49.5** **48.8***	Yes [11] Yes

* post-bronchodilator values

ARTERIAL BLOOD GAS STUDIES

Exhibit	**Date**	**pCO_2**	**pO_2**	**Qualifying**
DX 9	2/5/02	37	72	No
DX 14	4/4/02	36	68	No

All values are pre-exercise

Narrative Reports

Dr. Glen R. Baker, Jr. examined the Claimant on February 5, 2002. (DX 8). Dr. Baker considered the following: symptomatology (sputum, wheezing, dyspnea, cough, orthopnea, and shortness of breath at night), employment history (18 ¾ years as an underground coal miner working at the face as a shuttle car operator, and quitting in 1996), individual history (pneumonia, pleurisy, wheezing, chronic bronchitis, arthritis, and two mining accidents), family history (emphysema), smoking history (30 years at one pack per day, and continues to smoke), physical examination (bilateral expiratory wheezing), chest x-ray (1/0), PFT (mild obstructive defect), ABG (mild resting arterial hypoxemia), and an EKG (normal sinus rhythm). Based on this evidence, Dr. Baker diagnosed CWP based on the x-ray and Claimant's exposure to coal dust; COPD with mild obstructive defect based on the PFT; hypoxemia based on the ABG; and chronic bronchitis based on history of symptoms. Dr. Baker attributed the CWP to coal dust exposure only, and opined that the other conditions were the result of both coal dust exposure and cigarette smoking. Also, while he stated that Claimant suffered from a mild impairment caused by coal mine employment and cigarette smoking, he opined that Claimant was not disabled from a respiratory standpoint, and therefore, retains the respiratory capacity to perform the work of an underground coal miner or to do similarly arduous manual labor in a dust-free environment.

[10] Dr. Nausherwan Burki, an internist and pulmonologist, validated this PFT. (DX 11).

[11] The PFT report noted that Claimant was unable to go to plateau on either the pre or post-bronchodilator trials due to marked shortness of breath. Also, Dr. Lockey noted that Claimant's reported FVC comes from a tracing that approaches but does not meet the ATS definition for an adequate plateau, but he explained that this deviation is slight and would have minimum impact on reported values for FVC and FEV1/FVC ratio.

Dr. James Lockey, an internist, pulmonologist, and B-reader, examined the Claimant on April 4, 2002. (DX 14; EX 3). Dr. Lockey considered the following: symptomatology (shortness of breath, daily productive cough, sputum, and wheezing), employment history (18 to 19 years, ending in 1996; most recently he worked as a shuttle car operator and on the belt line at the face), individual history (pneumonia and GERD, family history (black lung), smoking history (40 years at one pack per day, and continues to smoke), physical examination (on auscultation, prolonged expiratory phase with scattered rhonchi and wheezing), chest x-ray (negative), PFT (moderate to severe airway obstruction with no significant response to bronchodilators), ABG (decreased PO2 for a 63-year old male), and an EKG (normal). Based on these findings, Dr. Lockey found no indication of any type of occupational pulmonary disorder, but instead diagnosed chronic bronchitis with moderate to severe airway obstruction and mild hypoxia secondary to a 40 pack-year history of smoking. He explained that the lack of x-ray evidence of CWP, along with a moderate to severe airway obstruction with no significant response to bronchodilators, is consistent with a history of chronic bronchitis secondary to a 40 pack-year history of cigarette smoking. Dr. Lockey concluded that based on the severe airway obstruction that Claimant would not be medically qualified to do his normal job tasks in the coal mining industry or similar type job tasks in a dust-free environment.

Dr. Lockey was deposed by the Employer on December 2, 2003, when he repeated the findings of his earlier written report. (EX 1). In addition, Dr. Lockey explained that moderate to severe airway obstruction in a coal miner is not seen unless there is obvious x-ray evidence of progressive massive fibrosis. (EX 3). He went on to explain that since progressive massive fibrosis was not seen in this case, Claimant's degree of airway obstruction is not associated with coal dust exposure, but instead, is associated with cigarette smoking. Also, he stated that Claimant did not have any restrictive defect, which is usually more dominant with CWP. Finally, Dr. Lockey explained that he has examined individuals who have similar histories of cigarette smoking and who have never been employed in coal mining, and has found those people to have similar abnormalities to those found in Claimant.

Dr. Thomas Jarboe, an internist, pulmonologist, and B-reader, submitted a medical evidence review on December 11, 2003. (EX 1, 6). Dr. Jarboe considered Dr. Lockey's April 4, 2002 report and Dr. Baker's February 5, 2002 report. Weighing the x-ray evidence, and based primarily on Dr. Wiot's reading, Dr. Jarboe determined that the radiographic evidence does not support a diagnosis of pneumoconiosis. In addition, Dr. Jarboe opined that there was insufficient physiological evidence of CWP, but he diagnosed a moderate to moderately severe respiratory impairment in the form of airflow obstruction that was caused by smoking. He explained that the preserved FVC and reduced FEV1 pattern seen in the PFT is consistent with a cigarette smoking impairment. He went on to state that coal dust impairments are usually represented by a proportionate reduction in both FVC and FEV1. Dr. Jarboe concluded by affirming Dr. Lockey's conclusion that Claimant has a totally and permanently disabling respiratory impairment, as his FEV1 falls below the federal limits for disability in coal workers. As a result, he opined that Claimant does not retain the respiratory capacity to do his last coal mining job or work of similar physical demand in a dust-free environment.

Dr. Jarboe was deposed by the Employer on February 17, 2005, when he repeated the findings of his earlier written report. (EX 6). In preparation for this deposition, Dr. Jarboe also

reviewed the newly submitted treatment records. Based on these records, Dr. Jarboe stated that the opinions expressed in his previous report remain unchanged because the office notes indicate that Claimant's obstructive lung disease has an asthmatic component, and even if he had simple pneumoconiosis, it would not create the pattern of abnormality that was seen in the treatment records. Next, considering the fact that Claimant left the mining industry seven years prior to the examinations by Drs. Lockey and Baker, Dr. Jarboe opined that Claimant's symptoms of chronic bronchitis would not be related to coal dust exposure due to the fact that when most miners leave the mining industry they will stop coughing or notice a marked improvement in their cough once dust exposure ceases. Finally, Dr. Jarboe noted that Claimant's continued smoking habit until November 2003 was an irritant sufficient in and of itself to produce his ongoing symptoms.

Dr. Jarboe submitted a supplementary medical evidence review on February 20, 2005, in which he considered the newly submitted treatment records in relation to the findings from his earlier report. (EX 5). Dr. Jarboe stated that these additional records do nothing to change the opinions expressed in his 2003 report. In addition, he opined that the treating notes do not support a diagnosis of CWP in that they never mention CWP as a causative of Claimant's respiratory problems. They do, however, relate Claimant's COPD to tobacco abuse, and they also reveal treatment for a significant reversible component to airway disease which can be associated with cigarette induced airflow obstruction or asthma. Finally, Dr. Jarboe notes that Claimant is treated with oxygen for his mild nocturnal desaturation (hypoxemia), but he opined that this condition was caused by chronic airflow obstruction with a reversible component which in turn, has been caused by a long history of smoking.

Hospitalization Records and Treatment Notes

The record includes treatment records that span October 16, 2003 through January 6, 2005. (EX 6). The relevant records are summarized below in chronological order: [12]

November 21, 2003 – Treatment note by Dr. Carrera: Patient presented with shortness of breath. He has known COPD and continues to smoke. Symptoms include dyspnea, cough, sputum production, and low grade fever. On examination, lungs show inspiratory and expiratory rhonchi with prolonged expiratory phase and faint breath sounds. X-ray shows no acute infiltrate, but is positive for COPD changes. Assessment: acute exacerbation of COPD.

February 5, 2004 – Treatment note by Dr. Carrera: Patient presented with a skin rash. The report, however, noted that Mr. Holbrook had stopped smoking.

May 14, 2004 – Treatment note by Dr. Smith: Physical examination revealed clear lungs with decreased breath sounds bilaterally. Patient was referred to a pulmonologist due to his COPD.

[12] These records include an x-ray interpretation by Dr. Hilton, and a reference by Dr. Carrera to a second study. There is no evidence in the record as to the x-ray reading credentials of these physicians. Also, these interpretations were all related to the treatment of Claimant's condition, and not for the purpose of determining the existence or extent of pneumoconiosis. Finally, there is no record of the film quality for any of these x-rays. As a result, the x-ray results are not in compliance with the quality standards of §718.102 and Appendix A to Part 718. Therefore, I accord the x-ray interpretations contained in the treatment records no weight for the purpose of determining whether Claimant suffers from pneumoconiosis under § 718.202(a)(1).

May 17, 2004 – X-ray report by Dr. Hilton: A few calcified granulomas are seen in the perihilar regions. There are also several small areas of post fibrotic change in the right costophrenic angle. Impression: Post inflammatory and healed calcific granulomatous lung disease.

June 8, 2004 – New patient analysis by Dr. Smith: Patient is a retired coal miner who quit smoking in November 2003. His physical examination revealed distant breath sounds and hyper-resonance to percussion. He has a history of CWP and lung disease related to previous tobacco use.

November 9, 2004 – Treatment note by Dr. Smith: Physical examination revealed clear lungs with decreased breath sounds in the bases. Patient has COPD but refuses to go see a pulmonologist. He will have an overnight oximetry to assess whether he needs oxygen.

January 6, 2005 – Treatment note by Dr. Smith: Patient presented with chest pain and severe shortness of breath on exertion, which is most likely due to his severe COPD. He has had an overnight oximetry which showed that he qualifies for oxygen. Physical examination shows scattered wheezes in his lung with decreased breath sounds throughout. Assessment: Chest pain and shortness of breath in a patient with cardiac risk factors. He will be scheduled for a stress test due to his severe COPD, which currently requires oxygen.

PREVIOUSLY SUBMITTED MEDICAL EVIDENCE

X-RAYS

Exhibit	Date of X-ray	Date of Reading	Physician / Credentials	Interpretation
DX 1	11/17/97	11/17/97	Dahhan, B-reader	Negative
DX 1	11/17/97	12/03/97	Sargent, BCR, B-reader	Negative
DX 1	11/17/97	01/12/98	Wiot, BCR, B-Reader	Negative
DX 1	11/17/97	01/14/98	Shipley, BCR, B-reader	Negative
DX 1	03/05/98	03/05/98	Perma, B-reader	Negative

PULMONARY FUNCTION TESTS

Exhibit/ Date	Co-op./ Undst./ Tracings	Age/ Height[13]	FEV_1	FVC	MVV	FEV_1/ FVC	Qualifying Results
DX 1 9/12/94	Poor/ Yes	55 64.4”	1.0 1.11*	1.18 2.09*		85 53*	Invalid[14]

[13] The fact finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). While the majority of the PFT reports included in the previously submitted evidence support a height determination of 64.5 inches, the newly submitted PFT reports unanimously support a height of 65 inches. Therefore, I find the Miner’s height to be 65 inches.

[14] Dr. Kabani noted that due to poor performance this study was uninterruptible.

DX 1 9/19/94	Poor/ Good/ Yes	55 64”	1.85	2.71	82.01	68	No
DX 1 11/17/97	Fair/ Good/ Yes	58 64.5”	1.9 1.95*	3.15 3.29*	74.22 92.34*	60 59*	No No*
DX 1 3/5/98	Maximal effort/[15] Yes	58 64.5”	2.25 2.29*	3.4 3.54*	---	66.1 64.7	No No*

* indicates post-bronchodilator values

ARTERIAL BLOOD GAS STUDIES

Exhibit	**Date**	**pCO_2**	**pO_2**	**Qualifying**
DX 1	11/16/84	34.9 34.7*	64.8 94*	Yes No*
DX 1	09/12/94	34.3	85	No
DX 1	02/09/95	34.2	68	No
DX 1	11/17/97	35 35.5*	77.5 93.5*	No No*
DX 1	01/23/98	32.9	66	Yes
DX 1	01/23/98	30	57	Yes
DX 1	03/05/98	33	70	No

* indicates post-exercise values

Narrative Reports

Dr. A. Dahhan examined the Claimant on November 17, 1997. (DX 1). Dr. Dahhan considered the following: symptomatology (sputum, wheezing, dyspnea, cough, orthopnea, and ankle edema), employment history (20 years coal mine employment with 18 underground operating a shuttle car), individual history (frequent colds, pneumonia, pleurisy, attacks of wheezing, chronic bronchitis, bronchial asthma, and arthritis), no significant family history, smoking history (38 years at a pack per day, but he cut back to ½ pack per day at some point), physical examination (upper resonance on percussion, scattered expiratory wheeze with no crepitation on auscultation, and mild obstructive ventilatory abnormality), chest x-ray (0/0), PFT (non-qualifying), ABG (non-qualifying), and an EKG (normal tracings). Dr. Dahhan diagnosed chronic bronchitis caused by smoking. He further noted that Claimant has had a lengthy smoking habit, and that he has not had any exposure to coal dust since 1995. This duration of absence, he opined, was sufficient to cause cessation of any industrial bronchitis that he may have had. In addition, Dr. Dahhan found no evidence of progressive massive fibrosis or

[15] This report noted that the FVC comes from a tracing that does not meet the ATS definition for an adequate plateau. Therefore, if forced expiration had continued, the FVC would be higher than the value reported, and the FEV1/FVC ration would be lower than the value reported.

complicated CWP that can cause a secondary obstructive ventilatory abnormality. As a result, Dr. Dahhan concluded that while Claimant had a mild respiratory impairment, he retains the respiratory capacity to continue his previous coal mining work or job of comparable physical demand.

Dr. Lockey examined the Claimant on March 5, 1998 and submitted a report dated April 2, 1998. (DX 1). Dr. Lockey considered the following: symptomatology (shortness of breath, productive cough, wheezing, and dyspnea on exertion), employment history (19 years coal mine employment, 15 years of which was as a shuttle car operator), individual history (hospitalization for episodes of pneumonia and a pulmonary effusion resulting from a rib injury), family history (black lung and breathing problems), smoking history (currently smokes), physical examination (scattered mid to late inspiratory crackles along the left base, but otherwise clear), chest x-ray (0/0), PFT (pre and post-bronchodilator results in regard to FVC and FEV1 were normal; there was a decrease in the FEV1/FVC ration consistent with mild airway obstruction; there is no significant response to bronchodilators), ABG (PO2 is slightly reduced for a 58-year-old man), and an EKG (normal). As noted on the spirometric testing, Dr. Lockey diagnosed a mild airway obstruction secondary to Claimant's past and current ongoing cigarette smoking. He also opined that Claimant does not have findings consistent with CWP, and the PFT and ABG values are above federal standards. Dr. Lockey concluded that Claimant is physically able from a pulmonary standpoint to do his usual coal mining employment or comparable work in a dust-free environment

Hospitalization Records and Treatment Notes

The previously submitted record includes a large number of treatment records covering a 15 year span. (DX 1). The legible, relevant records are summarized below in chronological order: [16]

April 5, 1982 – X-ray report by Dr. Simmons: Lungs appear to be clear. No active disease of the chest.

April 12, 1982 – X-ray report by Dr. Thomas: Lungs are free of infiltrate. No active cardio-pulmonary disease.

November 16, 1984 – ABG report: See chart above.

October 16, 1991 – Examination report by Dr. Morfesis: Claimant complaining of abdominal pain resulting from an injury to his right rib cage. It was stressed that if Claimant does not quit smoking that his peptic ulcer disease will probably continue to recur over and over again. The

[16] These records include a number of x-ray interpretations. There is no evidence in the record as to the x-ray reading credentials of these physicians. Also, these interpretations were all related to the treatment of Claimant's condition, and not for the purpose of determining the existence or extent of pneumoconiosis. Finally, there is no record of the film quality for any of these x-rays. As a result, the x-ray results are not in compliance with the quality standards of §718.102 and Appendix A to Part 718. Therefore, I accord the x-ray interpretations contained in the treatment records no weight for the purpose of determining whether Claimant suffers from pneumoconiosis under § 718.202(a)(1).

lungs were clear to auscultation except from some rales at the right base, probably consistent with trauma. Claimant is tender and has less movement of air on the right side but it is still adequate.

October 16, 1991 – X-ray report by Dr. Tiu: The lung fields are clear. Bronchovascular markings are within normal limits. No pulmonary infiltrates are seen. No pleural effusion or pneumothorax is identified. Impression: Normal chest. Findings highly suspicious for acute fractures involving the anterior ends of the 7th, 8th, and 9th ribs. Old fracture of the 9th and 10th posterior rib is also noted.

October 17, 1991 – X-ray report by Dr. Tiu: The lung fields are clear. Bronchovascular markings are within normal limits. No pleural effusion or pneumothorax is identified. Impression: No active disease except for finding an old fracture of the right 9th rib.

July 23, 1993 – X-ray report by Dr. Srisumrid – The lung fields are clear. Bronchovascular markings are within normal limits. No pulmonary infiltrates are seen. Impression: Normal chest.

August 26, 1994 – Examination note by Dr. Kabani: Claimant complaining of shortness of breath on exertion and cough. Lung examination revealed clear lungs with decreased air entry bilaterally. Claimant worked in the coal mines for the past 15 years. Impression: COPD and pneumoconiosis.

September 12, 1994 – PFT and ABG report: See chart above.

September 13, 1994 – X-ray report by Dr. Tiu: Lung fields are clear. Bronchovascular markings are within normal limits. No pleural effusion or pneumathorax is identified. Incidental finding of emphysematous changes is noted. Impression: No active disease except for emphysematous changes.

September 19, 1994 – PFT report: see chart above.

February 9, 1995 – ABG report: see chart above.

February 11, 1995 – X-ray report by Dr. Dahhan: The lung fields are clear with no pulmonary infiltrates. Conclusion: chest negative.

February 17, 1995 – Discharge summary by Dr. Ahmed: 17 year coal miner and a smoker. Admitted for pain in the right lower chest that radiated to the right upper quadrant associated with nausea and vomiting. He also has a cough and a low grade fever. The lung examination showed bilateral expiratory rhonchi. Chest x-ray revealed increased interstitial markings with no abnormalities.

February 2, 1996 – Medical record form by Dr. Stolzfus: Claimant has a history of CWP and complains of pain in his left lung, heavy cough, sputum, shortness of breath. He worked 18 years in the mines, smoked a pack of cigarettes a day for 30 years, has a history of pneumonia,

and draws Black Lung benefits from the state. Physical examination shows that lungs are clear. Impression: CWP and COPD.

April 16, 1996 – Examination note by Dr. Stolzfus: Claimant complaining of shortness of breath on exertion, sputum production, and coughing. Lung examination revealed a few rhonchi. Impression: CWP and COPD.

August 28, 1996 – Examination note by Dr. Stolzfus: Physical examination shows that lungs are clear. Impression: CWP.

August 28, 1996 – Letter from Dr. Stoltzfus: Claimant has CWP and has worked in the mines for 18 years. He also has COPD with episodes of shortness of breath and dyspnea on exertion. Based on this assessment, Claimant is not able to engage in gainful employment.

October 30, 1996 – Medical record form by Dr. Stolzfus: Claimant has a history of CWP. Physical examination shows that lungs are clear. Impression: CWP.

October 30, 1996 – Examination note by Dr. Stolzfus: Physical examination shows that lungs are clear. Impression: CWP.

February 12, 1997 – Medical record form by Dr. Stolzfus: Claimant complaining of shortness of breath. Physical examination shows that lungs are clear. Impression: CWP.

March 5, 1997 – X-ray report by Dr. Dahhan: Hyperinflated lungs with no other cardiopulmonary abnormalities.

January 14, 1998 – Medical record form by Dr. Stolzfus: Claimant complaining of smothering, chest pain, shortness of breath, and cough. Physical examination reveals clear lungs with no rales or wheezes. Impression: CWP.

January 23, 1998 – Examination note by Dr. Dahhan: Pack a day smoker, reduced to ½ packs per day 2 years ago, who worked in the mining industry for 20 years, quitting in 1995. Symptoms include cough, sputum, wheeze, chest pain, low grade fever, nausea, frequent back pain, and dyspnea on exertion. Examination of the lungs shows increased AP diameter with hyperresonance to percussion, auscultation revealed good use of air entries to the lungs with bilateral scattered expiratory wheeze, a few basil crepitations are noted in the left, thorax is not clear on coughing. Discharge diagnosis: Possible left lower lobe pneumonia and chronic obstructive lung disease.

January 23, 1998 – X-ray report by Dr. Dahhan: Hyperinflated lungs consistent with emphysema and no other cardiopulmonary abnormalities.

January 23, 1998 – Two ABG reports: see chart above.

April 14, 1998 – Medical record form by Dr. Stolzfus: Claimant complains of flu and productive cough. Physical exam reveals lungs to be clear. Impression: Acute respiratory infection and CWP.

Smoking History

At the March 25, 2002 deposition, Claimant stated that he smoked for 40 years. (DX 21:9-10). At the hearing, however, Claimant testified that he quit smoking sometime in 2003. (Tr. 20). Thus, Claimant testified that he smoked a total of 41 ½ years at a rate of one pack per day or less. (Tr. 20, 28). Dr. Baker's report states that Claimant smoked for 30 years at one pack per day, and continues to smoke. (DX 8). Dr. Lockey reported that Claimant smoked for 40 years at one pack per day, and continues to smoke. (DX 14). Dr. Smith noted that Claimant quit smoking in November 2003. (EX 6). As Dr. Lockey's and Dr. Smith's reports generally support Claimant's testimony, I find that Claimant smoked for 41 ½ years at a rate of one pack per day, or 41.5 pack years; but that he quit in November 2003.

DISCUSSION AND APPLICABLE LAW

Mr. Holbrook's claim was made after March 31, 1980, the effective date of Part 718, and must therefore be adjudicated under those regulations. To establish entitlement to benefits under Part 718, Claimant must establish, by a preponderance of the evidence, that he:

1. Is a miner as defined in this section; and

2. Has met the requirements for entitlement to benefits by establishing that he:

   (i) Has pneumoconiosis (see § 718.202), and

   (ii) The pneumoconiosis arose out of coal mine employment (see § 718.203), and

   (iii) Is totally disabled (see § 718.204(c)), and

   (iv) The pneumoconiosis contributes to the total disability (see § 718.204(c)); and

3. Has filed a claim for benefits in accordance with the provisions of this part.

Section 725.202(d)(1-3); *see also* §§ 718.202, 718.203, and 718.204(c).

Subsequent Claim

The provisions of § 725.309 apply to new claims that are filed more than one year after a prior denial. Section 725.309 is intended to provide claimants relief from the ordinary principles of *res judicata*, based on the premise that pneumoconiosis is a progressive and irreversible disease. *See Lukman v. Director, OWCP*, 896 F.2d 1248 (10th Cir. 1990); *Orange v. Island Creek Coal Company*, 786 F.2d 724, 727 (6th Cir. 1986); § 718.201(c) (Dec. 20, 2000). The amended version of § 725.309 dispensed with the material change in conditions language and

implemented a new threshold standard for the claimant to meet before the record may be reviewed *de novo*. Section 725.309(d) provides that:

> If a claimant files a claim under this part more than one year after the effective date of a final order denying a claim previously filed by the claimant under this part, the later claim shall be considered a subsequent claim for benefits. A subsequent claim shall be processed and adjudicated in accordance with the provisions of subparts E and F of this part, except that the claim shall be denied unless the claimant demonstrates that one of the applicable conditions of entitlement (see § 725.202(d) miner. . .) has changed since the date upon which the order denying the prior claim became final. The applicability of this paragraph may be waived by the operator or fund, as appropriate. The following additional rules shall apply to the adjudication of a subsequent claim:
>
> (1) Any evidence submitted in conjunction with any prior claim shall be made a part of the record in the subsequent claim, provided that it was not excluded in the adjudication of the prior claim.
>
> (2) For purposes of this section, the applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based. For example, if the claim was denied solely on the basis that the individual was not a miner, the subsequent claim must be denied unless the individual worked as a miner following the prior denial. Similarly, if the claim was denied because the miner did not meet one or more of the eligibility criteria contained in part 718 of the subchapter, the subsequent claim must be denied unless the miner meets at least one of the criteria that he or she did not meet previously.
>
> (3) If the applicable condition(s) of entitlement relate to the miner's physical condition, the subsequent claim may be approved only if new evidence establishes at least one applicable condition of entitlement. . . .
>
> (4) If the claimant demonstrates a change in one of the applicable conditions of entitlement, no findings made in connection with the prior claim, except those based on a party's failure to contest an issue, shall be binding on any party in the adjudication of the subsequent claim. However, any stipulation made by any party in connection with the prior claim shall be binding on that party in the adjudication of the subsequent claim.

Section 725.309(d) (April 1, 2002).

Claimant's prior claim was denied after it was determined that he failed to establish any of the elements of entitlement. (DX 1). Consequently, the Claimant must establish, by a preponderance of the newly submitted evidence, at least one applicable condition of entitlement previously adjudicated against him. If Claimant is able to show that he has pneumoconiosis, that

his pneumoconiosis arose out of coal mine employment, or that he is totally disabled as a result of pneumoconiosis, then he will avoid having his subsequent claim denied on the basis of the prior denial.

Total Disability

Claimant may establish a material change in conditions by demonstrating that he is totally disabled from performing his usual coal mine work or comparable work due to pneumoconiosis under one of the five standards of § 718.204(b) or the irrebuttable presumption referred to in § 718.204(b). The Board has held that under § 718.204(b), all relevant probative evidence, both like and unlike must be weighed together, regardless of the category or type, in the determination of whether the Claimant is totally disabled. *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195 (1986); *Rafferty v. Jones & Laughlin Steel Corp.*, 9 B.L.R. 1-231 (1987). Claimant must establish this element of entitlement by a preponderance of the evidence. *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4 (1986).

The record does not include any evidence that Claimant suffers from complicated pneumoconiosis. Therefore, the irrebuttable presumption of § 718.304 does not apply.

Total disability can be shown under § 718.204(b)(2)(i) if the results of pulmonary function studies are equal to or below the values listed in the regulatory tables found at Appendix B to Part 718. The newly submitted record includes two pre-bronchodilator pulmonary functions studies that produced qualifying values equal to or below those found in Appendix B of Part 718. It also included one post-bronchodilator set of qualifying values. Even if Dr. Lockey's PFT report was excluded from consideration due to the deficiencies he noted, I find that the remaining PFT evidence supports a conclusion that Claimant is totally disabled. Therefore, I find that the preponderance of the PFT evidence is qualifying, and that Claimant has established total disability under subsection (b)(2)(i).

Total disability can be demonstrated under § 718.204(b)(2)(ii) if the results of arterial blood gas studies meet the requirements listed in the tables found at Appendix C to Part 718. The newly submitted ABG studies did not produce values that met the requirements of the tables found at Appendix C to Part 718. Therefore, I find that Claimant has failed to establish the existence of total disability under subsection (b)(2)(ii).

Total disability may also be shown under § 718.204(b)(2)(iii) if the medical evidence indicates that Claimant suffers from cor pulmonale with right-sided congestive heart failure. The record does not contain any evidence indicating that Claimant suffers from cor pulmonale with right-sided congestive heart failure. Therefore, I find that Claimant has failed to establish the existence of total disability under subsection (b)(2)(iii).

Section 718.204(b)(2)(iv) provides for a finding of total disability if a physician, exercising reasoned medical judgment based on medically acceptable clinical or laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevented the miner from engaging in his usual coal mine employment or comparable gainful employment.

Claimant's last coal mine employment as a shuttle car operator which mostly involved sitting all day in a shuttle car and required little heavy lifting. (Tr. 14-15).

The exertional requirements of the claimant's usual coal mine employment must be compared with a physician's assessment of the claimant's respiratory impairment. *Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000). Once it is demonstrated that the miner is unable to perform his usual coal mine work, a *prima facie* finding of total disability is made and the party opposing entitlement bears the burden of going forth with evidence to demonstrate that the miner is able to perform "comparable and gainful work" pursuant to § 718.204(b)(1). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988). Nonrespiratory and nonpulmonary impairments have no bearing on establishing total disability due to pneumoconiosis. § 718.204(a); Jewell *Smokeless Coal Corp. v. Street*, 42 F.3d 241 (1994). All evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing by a preponderance of the evidence the existence of this element. *Mazgaj v. Valley Camp Coal Co.*, 9 B.L.R. 1-201 (1986).

Drs. Jarboe, Lockey and Baker are the only physician to provide new evidence that addresses Claimant's level of impairment from a pulmonary or respiratory standpoint. Also, while the treatment records discuss Claimant's respiratory condition, they do not include any diagnosis of impairment, nor do they offer an opinion as to whether Claimant has the pulmonary capacity to perform his previous coal mine employment, or similarly arduous labor in a dust-free environment.

Dr. Baker concluded that based on an accurate smoking and employment history, physical examination, a non-qualifying ABG study, and a qualifying PFT, Claimant suffers from hypoxemia and COPD with a mild obstructive defect. He concluded that Claimant was not totally disabled from pulmonary standpoint, and thus, able to perform the work of an underground coal miner or to do similarly arduous manual labor in a dust-free environment. While Dr. Baker considered the objective data to reach his conclusions, he provided no explanation as to why he did not feel that Claimant was totally disabled despite the qualifying PFT values. As a result, while I find his opinion to be well-documented, I find his failure to explain why he disregarded the objective evidence before him severely undermines his opinion. Therefore, I find that Dr. Baker's report is not well-reasoned, and accord it little weight.

Dr. Lockey, and internist and pulmonologist, concluded that based on an accurate smoking and employment history, physical examination, a non-qualifying ABG, and a qualifying PFT, that Claimant suffered from mild hypoxemia and a moderate to severe airway obstruction with no significant response to bronchodilators. He opined that Claimant was totally disabled from a pulmonary standpoint, and thus, was medically unable to do his normal job tasks in the coal mine industry or similar type job tasks in a dust-free environment. Also, while Dr. Lockey admitted that the post-bronchodilator PFT values he relied on to reach his conclusion did not meet the ATS definition for an adequate plateau, and this deficiency would have an impact on the FVC and FEV1/FVC ratio, he explained that the deficiency in the PFT was "slight and would have minimum impact." A report which is seriously flawed may be discredited. *Goss v. Eastern Assoc. Coal Corp.*, 7 B.L.R. 1-400 (1984). But based on Dr. Lockey's explanation, I do not find the PFT he considered to be "seriously flawed." Therefore, despite the noted deficiency, and

bolstered by Dr. Lockey's superior credentials, I find his report to be well-reasoned and well-documented, and thus, accord it probative weight.

Dr. Jarboe, an internist and pulmonologist, reviewed both Dr. Baker's and Dr. Lockey's examination reports, and concurred with Dr. Lockey's opinion that Claimant was totally disabled from a pulmonary standpoint. Specifically, Dr. Jarboe stated that since the FEV1 fell below the federal limits for disability in coal workers, Claimant did not retain the respiratory capacity to do his last coal mining job or work of similar physical demand in a dust-free environment. Due to the fact that Dr. Jarboe considered not only Dr. Lockey's PFT with the noted deficiencies, but also Dr. Baker's PFT, which was validated by Dr. Burki, I find this opinion to be more comprehensive. In addition, as Dr. Jarboe's opinion is supported by the objective evidence he considered, I find his opinion to be well-reasoned and well-documented. Therefore, bolstered by Dr. Jarboe's superior credentials, I find his report to be well-reasoned and well-documented, and thus, accord it substantial probative weight.

The newly submitted medical opinion evidence includes one unreasoned report finding that Claimant is not totally disabled from a pulmonary standpoint, and two well-reasoned reports concluding that he is totally disabled. Therefore, I find that Claimant has establish by a preponderance of the newly submitted evidence that he suffers from a total pulmonary disability under § 718.204(2)(b)(iv).

Considering the newly submitted medical evidence, Claimant has establish that he is totally disabled under subsection (b)(2)(i) and (iv). Therefore, after weighing all of the newly submitted evidence concerning total disability together under §718.204 (b)(2), I find that Claimant has established that he is totally disabled from a respiratory standpoint.

I also find that the newly submitted evidence is "qualitatively" different from the previously submitted medical evidence. First, of the five valid PFTs prior to 2002, none reflected qualifying values. On the other hand, all three of the newly submitted PFTs qualified. Second, neither of the previously submitted medical reports found Claimant to be totally disabled. In contrast, the newly submitted narrative reports, both finding Claimant to be totally disabled from a pulmonary standpoint, were well-reasoned. Based on these qualitative differences in the medical evidence, I find that Claimant has demonstrated that he is totally disabled, which constitutes a material change in conditions as required under §725.309 (d). Therefore, Claimants subsequent claim will not be denied on the basis of the prior denial, and thus, in order to receive benefits, he must satisfy the remaining requirements of §718, considering both the old and new evidence.

Pneumoconiosis

Claimant has the burden of proving the existence of pneumoconiosis, as well as every element of entitlement, by a preponderance of the evidence. *See Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994).

Pneumoconiosis is defined by the regulations:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis.
>
> (1) *Clinical Pneumoconiosis*. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) *Legal Pneumoconiosis*. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For the purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

Sections 718.201(a-c).

Section 718.202(a) sets forth four methods for determining the existence of pneumoconiosis.

(1) Under § 718.202(a)(1), a finding that pneumoconiosis exists may be based upon x-ray evidence. In this claim the record contains nine interpretations of four chest x-ray, and one quality-only interpretation.

Dr. Dahhan, a B-reader, and Drs. Shipley, Wiot, and Sargent, all dually certified radiologists and B-readers, found the November 17, 1997 x-ray to be negative for pneumoconiosis. There were no positive readings. Therefore, I find that the November 17, 1997 x-ray is negative for the disease.

Dr. Perma, a B-reader, interpreted the March 5, 1998 film as negative for pneumoconiosis. There were no positive readings. Therefore, I find that the March 5, 1998 film is negative for the presence of pneumoconiosis.

Dr. Baker interpreted the February 5, 2002 film as positive for pneumoconiosis. Dr. Wiot, a radiologist and B-reader read the film as negative for the disease. Base on his superior credentials, I accord Dr. Wiot's reading more probative weight than that of Dr. Baker. Therefore, I find that the February 5, 2002 film is negative for the presence of pneumoconiosis.

Dr. Lockey, a B-reader, and Dr. Wiot read the April 4, 2002 film as negative for pneumoconiosis. There were no positive readings. Therefore, I find the April 4, 2002 to be negative for the disease.

I have determined that all of the x-ray interpretations of record are negative for pneumoconiosis. In addition, all of the physicians with advanced x-ray interpretation credentials have read the films to be negative. Furthermore, of the nine interpretations of record, all but one was read as negative. Therefore, I find that Claimant has not met his burden of proof, and has not established the presence of pneumoconiosis under subsection (a)(1).

(2) Under § 718.202(a)(2), a determination that pneumoconiosis is present may be based, in the case of a living miner, upon biopsy evidence. The evidentiary record does not contain any biopsy evidence. Therefore, I find that the Claimant has failed to establish the existence of pneumoconiosis through biopsy evidence under subsection (a)(2).

(3) Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found to be applicable. In this case, the presumption of § 718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis. Section 718.305 is not applicable to claims filed after January 1, 1982. Finally, the presumption of § 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982. Therefore, Claimant cannot establish pneumoconiosis under subsection (a)(3).

(4) The fourth and final way in which it is possible to establish the existence of pneumoconiosis under § 718.202 set forth in subsection (a)(4) which provides in pertinent part:

> A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

§ 718.202(a)(4).

This section requires a weighing of all relevant medical evidence to ascertain whether or not the claimant has established the presence of pneumoconiosis by a preponderance of the evi-

dence. Any finding of pneumoconiosis under § 718.202(a)(4) must be based upon objective medical evidence and also be supported by a reasoned medical opinion. A reasoned opinion is one which contains underlying documentation adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which he bases his diagnosis. *Oggero v. Director, OWCP*, 7 B.L.R. 1-860 (1985). A brief and conclusory medical report which lacks supporting evidence may be discredited. *See Lucostic v. United States Steel Corp.*, 8 B.L.R. 1-46 (1985); *see also*, *Mosely v. Peabody Coal Co,.* 769 F.2d 257 (6th Cir. 1985). Further, a medical report may be rejected as unreasonable where the physician fails to explain how his findings support his diagnosis. *See Oggero*, 7 B.L.R. 1-860. Finally, a medical report containing the most recent physical examination of the miner may be properly accorded greater weight as it is likely to contain a more accurate evaluation of the miner's current condition. *Gillespie v. Badger Coal Co.*, 7 B.L.R. 1-839 (1985). *See also Bates v. Director, OWCP*, 7 B.L.R. 1-113 (1984) (more recent report of record entitled to more weight than reports dated eight years earlier); *Kendrick v. Kentland-Elkhorn Coal Co.*, 5 B.L.R. 1-730 (1983).

The newly submitted evidentiary record contains three physicians' opinions concerning the existence of pneumoconiosis. Dr. Baker examined Claimant, and based on a chest x-ray and coal dust exposure he diagnosed CWP, and based on 18 ¾ years coal mine employment, a 40 pack-year smoking history, a physical examination, a qualifying PFT, a non-qualifying ABG, and Claimant's history of symptoms, he diagnosed COPD, mild hypoxemia, and chronic bronchitis caused by cigarette smoking and coal dust exposure. While Dr. Baker set forth clinical observations and findings, I find his reasoning is not supported by adequate data. First, under § 718.202(a)(1) above, due to Dr. Wiot's superior credentials, I accorded greater probative weight to Dr. Wiot's negative reading of Claimant's chest x-ray than the positive reading by Dr. Baker. Second, the ABG results reported by Dr. Baker were non-qualifying. Third, the historical symptomatology Dr. Baker considered is not an objective finding. Fourth, Dr. Baker failed to provide any rationale for his opinion that Claimant's COPD was not wholly attributable to tobacco smoking. An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp*., 6 B.L.R. 1-1292 (1984). See *also Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984); *Duke v. Director, OWCP*, 6 B.L.R. 1-673 1983)(a report is properly discredited where the physician does not explain how underlying documentation supports his or her diagnosis). Since Dr. Baker failed to support his conclusion with any rationale, I find that his conclusion is not well-reasoned or documented. Therefore, I find that Dr. Baker's opinion does not constitute a reasoned medical opinion for the purposes of diagnosing pneumoconiosis, and is entitled to little weight.

Drs. Lockey and Jarboe, who are both internists, pulmonologists, and B-readers, considered the evidence of record, and determined that Claimant does not suffer from pneumoconiosis. In addition, these physicians provided detailed explanations as to why they believed Claimant's COPD was solely due to a long history of cigarette smoking and not the result of coal dust exposure. Furthermore, as their opinions are based on the objective evidence of record, I find them to be well-reasoned and well-documented. Therefore, bolstered by their advanced qualifications, I accord Dr. Lockey's and Dr. Jarboe's opinions substantial probative weight.

The newly submitted treatment records do not state a specific smoking or coal mine history. In addition, they do not provide any opinion concerning the existence of pneumoconiosis. As a result, I find these records to be a non-opinion concerning the issue of whether Claimant suffers from pneumoconiosis.

Turning to the previously submitted evidence, included are reports by Drs. Dahhan and Lockey. Neither of these physicians found evidence of pneumoconiosis. The treatment notes, however, include entries from Drs. Kabani and Stolzfus diagnosing pneumoconiosis. Dr. Kabani's 1994 report relied on symptoms, a physical examination, and 15 years of coal mine employment. However, due to Dr. Kabani's failure to consider Claimant's smoking history, I accord his opinion less weight. *Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993) (physician's opinion less probative where based on inaccurate smoking history).

Dr. Stolzfus submitted treatment reports spanning February 1996 through April 1998. During this two year period, he diagnosed CWP and COPD on seven occasions, but I note that he never stated that Claimant's COPD was caused by coal dust exposure. Dr. Stolfus considered a historical diagnosis of CWP, Claimant's symptoms, his coal mine employment, his smoking history, and six physical examinations. First, historical diagnoses and symptomatology are insufficient support for a diagnosis of pneumoconiosis under subsections (a)(4). Second, while he based his opinion on multiple physical examinations, all but the April 16, 1996 examination showed Claimant's lungs to be clear. As a result, while the evidence he considered does not appear to support a diagnosis of CWP, due to the fact that he considered objective evidence in reaching his conclusion, I find his opinion to be well-reasoned and well-documented. This opinion, however, is not entitled to substantial probative weight due to the fact that he failed to explain how mostly clear lung examinations support a diagnosis of CWP. Furthermore, Dr. Stolfus conducted the last of his physical examinations approximately four years prior to Dr. Lockey's most recent examination, so Dr. Lockey's report is more likely to contain a more accurate evaluation of Claimant's current condition. Finally, unlike Drs. Jarboe and Lockey, who are both internists and pulmonologists, Dr. Stolfus' August 28, 1996 letter stated that he was Claimant's family physician, but the record is otherwise void of any reference to his qualification. Therefore, bolstered by his status as Claimant's treating physician, I accord his opinion only probative weight.

The newly submitted record contains two reasoned and documented medical opinions concluding that Claimant does not suffer from clinical or legal pneumoconiosis, and one unreasoned opinion finding both clinical and legal pneumoconiosis. In addition, the only probative opinion from the prior record to diagnose pneumoconiosis is Dr. Stolfus' treatment record. However, as I have accorded substantial probative weight to the more recent opinions of Drs. Lockey and Jarboe, I find that the weight of the medical opinion evidence does not support the existence of pneumoconiosis, and thus, Claimant has failed to establish the presence of the disease by a preponderance of the evidence under subsection (a)(4).

Claimant has failed to establish the presence of pneumoconiosis under subsection (a)(1)-(4). Therefore, after weighing all evidence of pneumoconiosis together under §718.202 (a), I find that Claimant has failed to establish the presence of pneumoconiosis.

Total Disability Due to Pneumoconiosis

The amended regulations at § 718.204(c) contain the standard for determining whether Miner's total disability was caused by Miner's pneumoconiosis. Section 718.204(c)(1) determines that a miner is totally disabled due to pneumoconiosis if pneumoconiosis, as defined in § 718.201, is a "substantially contributing cause" of the miner's totally disabling respiratory or pulmonary impairment. Pneumoconiosis is a "substantially contributing cause" of the miner's disability if it has a material adverse effect on the miner's respiratory or pulmonary condition or if it materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment. §§ 718.204(c)(1)(i) and (ii). Section 718.204(c)(2) states that, except as provided in § 718.305 and § 718.204(b)(2)(iii), proof that the Miner suffered from a totally disabling respiratory or pulmonary impairment as defined by §§ 718.204(b)(2)(i), (ii), (iv), and (d) shall not, by itself, be sufficient to establish that the miner's impairment was due to pneumoconiosis.

Except as provided by § 718.204(d), the cause or causes of a miner's total disability shall be established by means of a physician's documented and reasoned medical report. § 718.204(c)(2). The Sixth Circuit Court of Appeals has stated that pneumoconiosis must be more than a "de minimus or infinitesimal contribution" to the miner's total disability. *Peabody Coal Co. v. Smith,* 12 F. 3d 504, 506-507 (6th Cir. 1997). The Sixth Circuit has also held that a claimant must affirmatively establish only that his totally disabling respiratory impairment (as found under § 718.204) was due - at least in part – to his pneumoconiosis. *Cf*. 20 C.F.R. 718.203(a); *Adams v. Director, OWCP*, 886 F.2d 818, 825 (6th Cir. 1988); *Cross Mountain Coal Co. v. Ward*, 93 F.3d 211, 218 (6th Cir. 1996)(opinion that miner's impairment is due to his combined dust exposure, coal workers pneumoconiosis as well as his cigarette smoking history is sufficient). More recently, in interpreting the amended provision at § 718.204(c), the Sixth Circuit determined that entitlement is not precluded by "the mere fact that a non-coal dust related respiratory disease would have left the miner totally disabled even without exposure to coal dust." *Tennessee Consolidated Coal Co. v. Director, OWCP [Kirk]*, 264 F.3d 602 (6th Cir. 2001). A miner "may nonetheless possess a compensable injury if his pneumoconiosis materially worsens this condition." *Id*.

Claimant has failed to establish by a preponderance of the evidence that he suffers from pneumoconiosis. As discussed above, I have found the reasoned opinions of Drs. Lockey and Jarboe to outweigh those presented by Dr. Stolfus. Therefore, based on the weight of Drs. Lockey and Jarboe's well-reasoned and well-documented opinion, and bolstered by their credentials as an internist and pulmonologist, I find that Claimant has failed to prove by a preponderance of the evidence that his total disability was caused, in part, by pneumoconiosis.

Complete Pulmonary Evaluation

The District Director is required to provide each miner applying for benefits with the "opportunity to undergo a complete pulmonary evaluation at no expense to the miner." §725.406(a). A complete evaluation includes a report of the physical examination, a chest x-ray, a pulmonary function study, and an arterial blood gas study. Reviewing courts have added to this burden by requiring the pulmonary evaluation be sufficient to constitute an opportunity to

substantiate a claim for benefits. *See Petry v. Director*, OWCP 14 B.L.R. 1-98, 1-100 (1990)(en banc); *see also Newman v. Director*, OWCP, 745 F.2d 1161 (8th Cir. 1984); *Prokes v. Mathews*, 559 F.2d 1057, 1063 (6th Cir. 1977).

In this decision and order, I have found that Claimant's complete pulmonary evaluation by Dr. Baker was unreasoned concerning both his pneumoconiosis diagnosis and his opinion as to total disability. This determination was based, in part, on his failure to explain why Claimant's pulmonary condition was not solely attributable to cigarette smoking, and his failure to explain why Claimant was not totally disabled despite a qualifying PFT. I note, however, that in both the pneumoconiosis analysis under §718.202(a)(4) and the total disability analysis under §718.204(b)(2)(iv), while Dr. Baker's opinion was given little weight, I still accorded it weight. Therefore, despite the defects in Dr. Baker's analysis, I do not find that his report is totally insufficient to constitute an opportunity to substantiate Mr. Holbrook's claim, and thus, I do not find that the District Director has failed in its obligation to provide the Claimant with an opportunity to undergo a complete pulmonary evaluation as required by §725.406(a). Furthermore, I have found that Drs. Lockey and Jarboe's well-reasoned and well-documented reports provide sufficient opinion evidence for the undersigned to make a determination as to the existence of pneumoconiosis, and whether Claimant's total disability was caused by pneumoconiosis. Stated another way, the undersigned, finds that the evidence of record is sufficient to reach a conclusion as to the elements of entitlement, and therefore, I find that remand is unwarranted.

Entitlement

The Claimant, Mr. Holbrook, has establish a material change in conditions sufficient to meet the statutory requirements of § 725.309(d), but has failed to prove that he suffered from pneumoconiosis, or that his total disability was due to pneumoconiosis. Therefore, Mr. Holbrook is not entitled to benefits under the Act.

Attorney's Fees

An award of attorney's fees is permitted only in cases in which the claimant is found to be entitled to benefits under the Act. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for the representation and services rendered in pursuit of the claim.

ORDER

IT IS ORDERED that the claim of Donald Holbrook for benefits under the Act is hereby DENIED.

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THOMAS F. PHALEN, JR.
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).